Attention: Medicaid Providers
Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

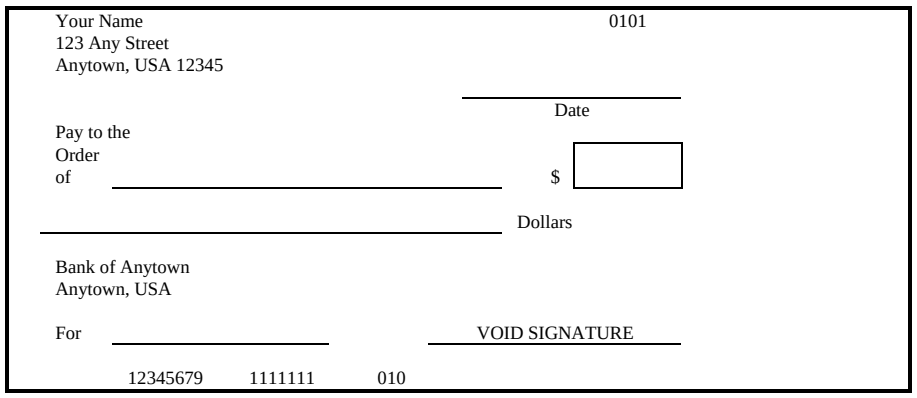
Request type (must be checked) □ Initial Request (Start) □ Change Request (Stop & Start) □ Cancel Request (Stop)

Electronic Data Systems offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service enables providers to have Medicaid payments deposited at a designated bank while continuing to receive Remittance and Status Reports (RA) at your mailing address of record. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check or a bank letter, and return it by mail or fax to:
EDS, 4905 Waters Edge, Raleigh, NC, 27606 OR 919-816-3186 ATTN – Finance
OR email to EFT@ncxix.hcg.eds.com

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we process this form. Initial requests normally take 2 checkwrites to finalize; changes require 1 additional checkwrite due to a cancellation period. Using EFT, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. EFT Payments are usually effective one business day after each checkwrite date. Contact Provider Services at 1- 800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.


Your Name
123 Any Street
Anytown, USA 12345

0101

Date

Pay to the Order of _____ $ _____

_____ Dollars

Bank of Anytown
Anytown, USA

For _____ VOID SIGNATURE

12345679 1111111 010

PROVIDER NAME_____

DATE_____ BILLING PROVIDER NUMBER_____

TO <u>STOP</u> USING AN ACCOUNT - COMPLETE THIS SECTION

BANK NAME_____

BRANCH ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

TO <u>START</u> USING AN ACCOUNT - COMPLETE THIS SECTION

BANK NAME_____

BRANCH ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

Under penalties of perjury, we hereby certify the checking or savings account(s) indicated above is/are under our direct control and access. Therefore, we authorize Electronic Data Systems to initiate, change or cancel credit entries to those checking or savings account(s) and the bank name(s)as indicated above.

NAME: _____ _____
Printed Authorized Signature

Contact Name _____ Phone Number _____

⇦ **<u>A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT. DO NOT SUBMIT DEPOSIT SLIPS.</u> IF YOU DO NOT HAVE A CHECK, OBTAIN A LETTER FROM YOUR BANK VERIFYING ACCOUNT & ROUTING NUMBER.**

***EACH PROVIDER NUMBER REQUIRES A SEPARATE REQUEST**

Revised 2/2006